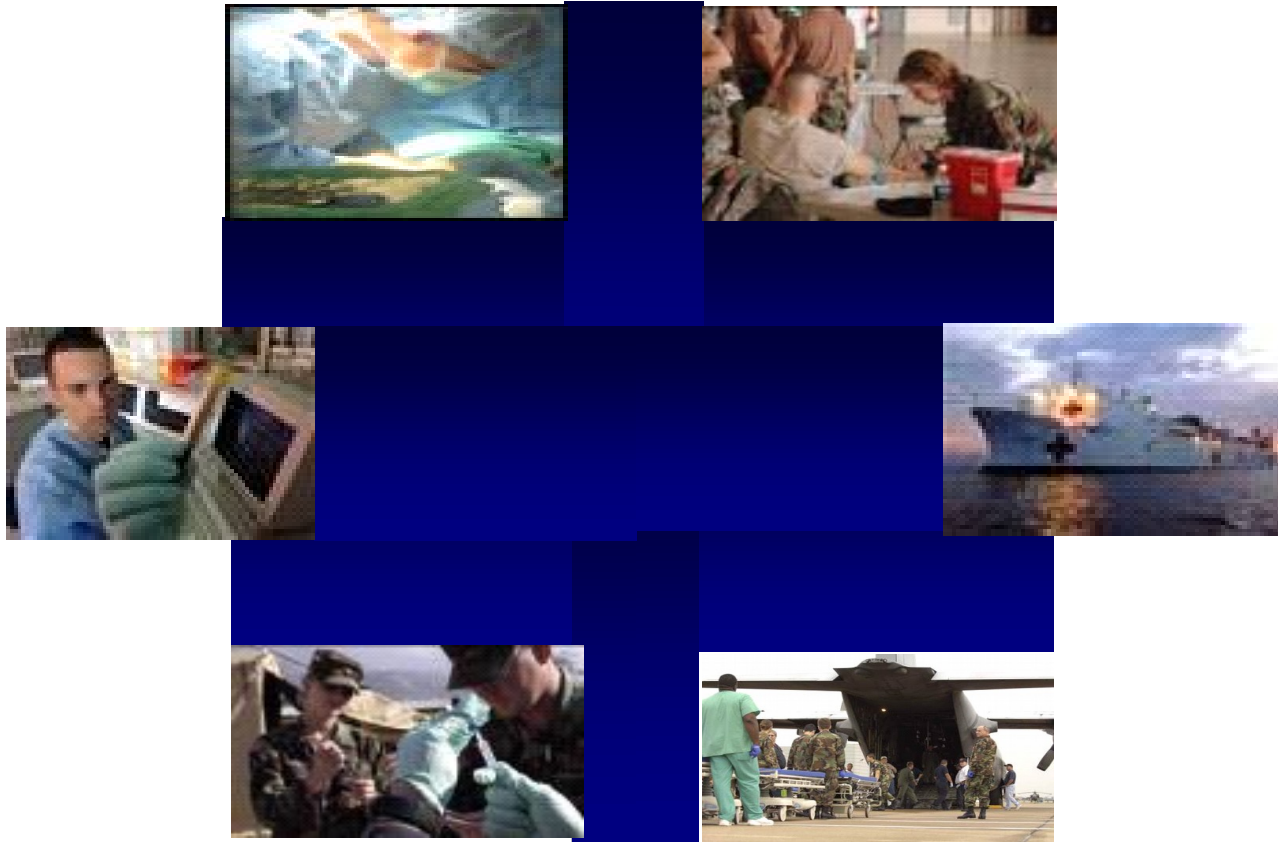


Military Health System Transformation



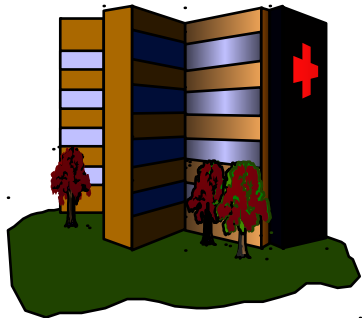
This document contains information exempt from mandatory disclosure under the Freedom of Information Act. Exemption 5 Applies.

July 2006

Military Health System Mission

In Peace & War

**Patient Care,
Sustain Skills
and Training**



**to Promote & Protect
Health of the Force**



**Deploy to
Support the
Combatant
Commanders**



**Manage Beneficiary
Care**

**Deploy Healthy
Force
Manage Beneficiary
Care**

**Deploy Medical
Force
Deploy to Homeland**

**Deploy Healthy
Force
Manage Beneficiary
Care**

World-Wide Fixed Asset Base



10 Medical Centers
60 Hospitals
387 Ambulatory Clinics
439 Dental Clinics
184 Veterinary Clinics
11 Medical Installations
2 Universities (Training)
7 Research Laboratories

Defense Medical Summary

■ **Over 1,200 Fixed Assets**

■ **\$20 B Replacement Value**

Military Health System - FY 2006

Snapshot

People + Money + Assets = Capability

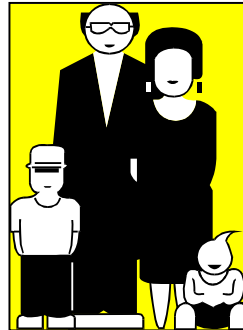
\$35.5 billion
Unified DoD Medical Budget



(Includes Accrual Fund payments)

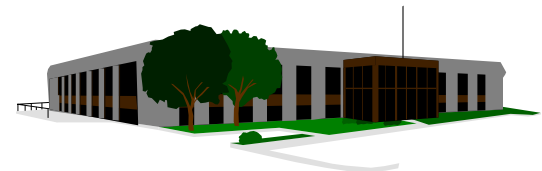


70 Inpatient Facilities
826 Outpatient Clinics



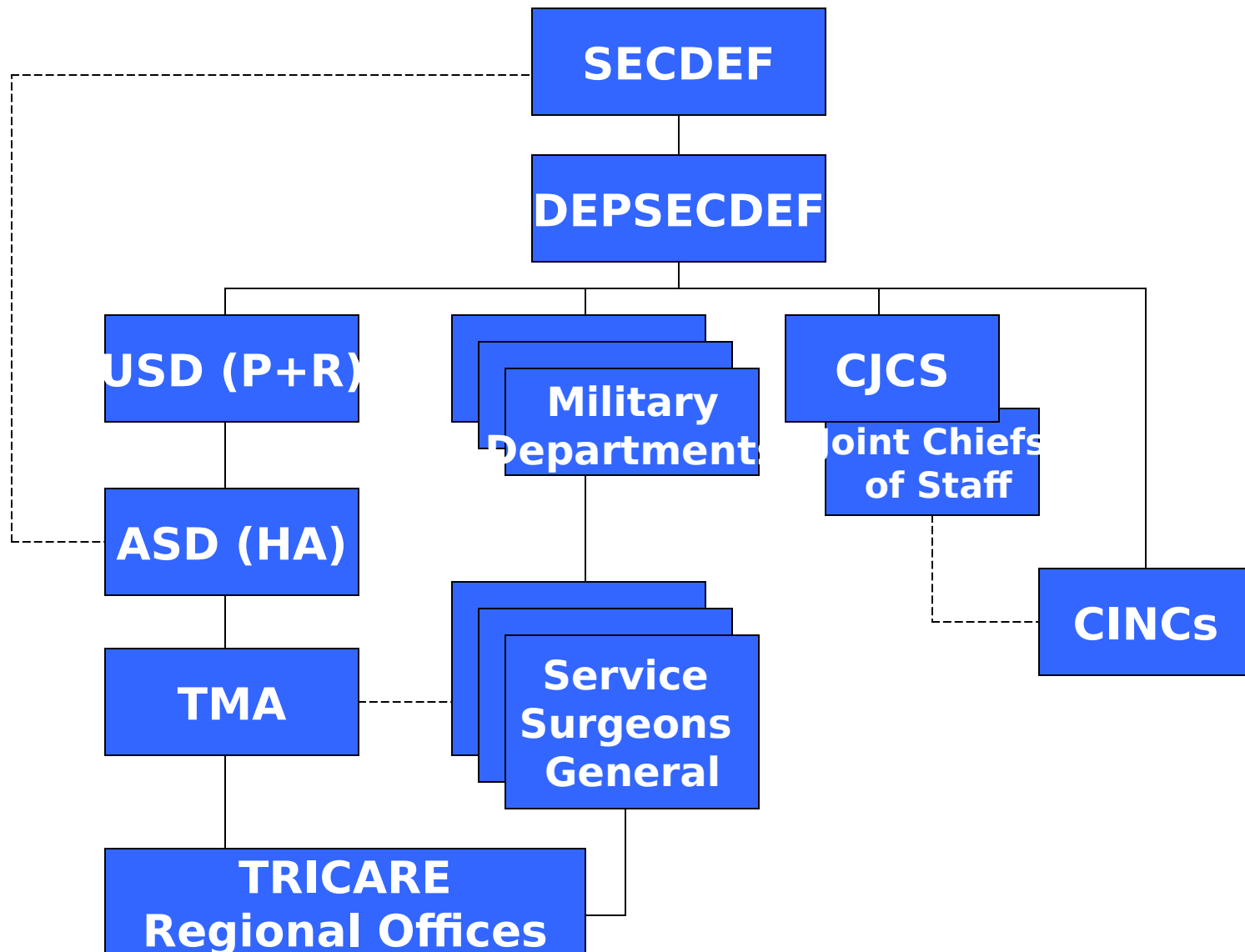
9.1 million
Beneficiaries

over 131 thousand military
and civilian medical personnel



TRICARE Network
210,000+ Private Sector Physicians
Virtually all Civilian Hospitals

Organizational Relationships



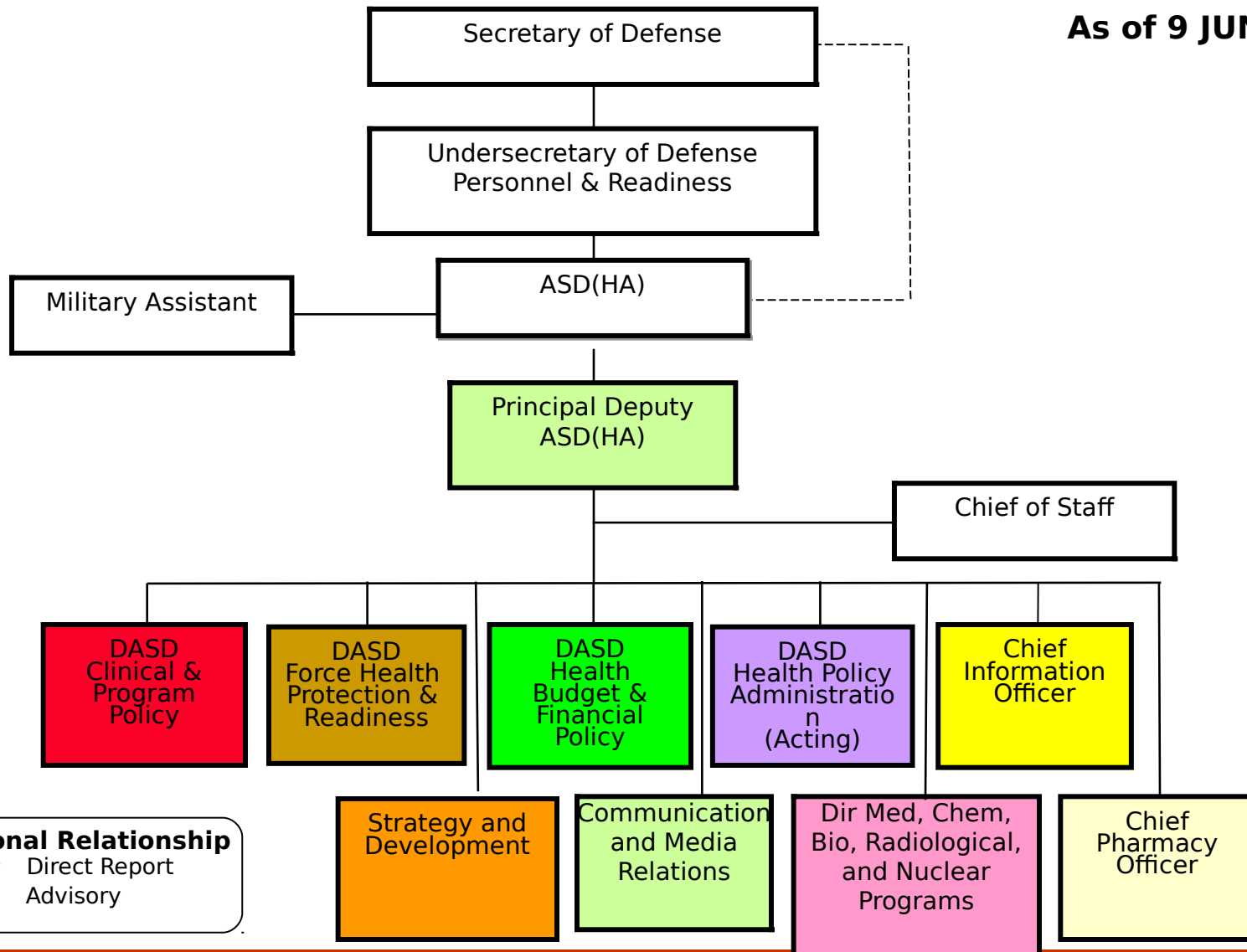


Organizational Structure



Office of the Assistant Secretary of Defense (Health Affairs)

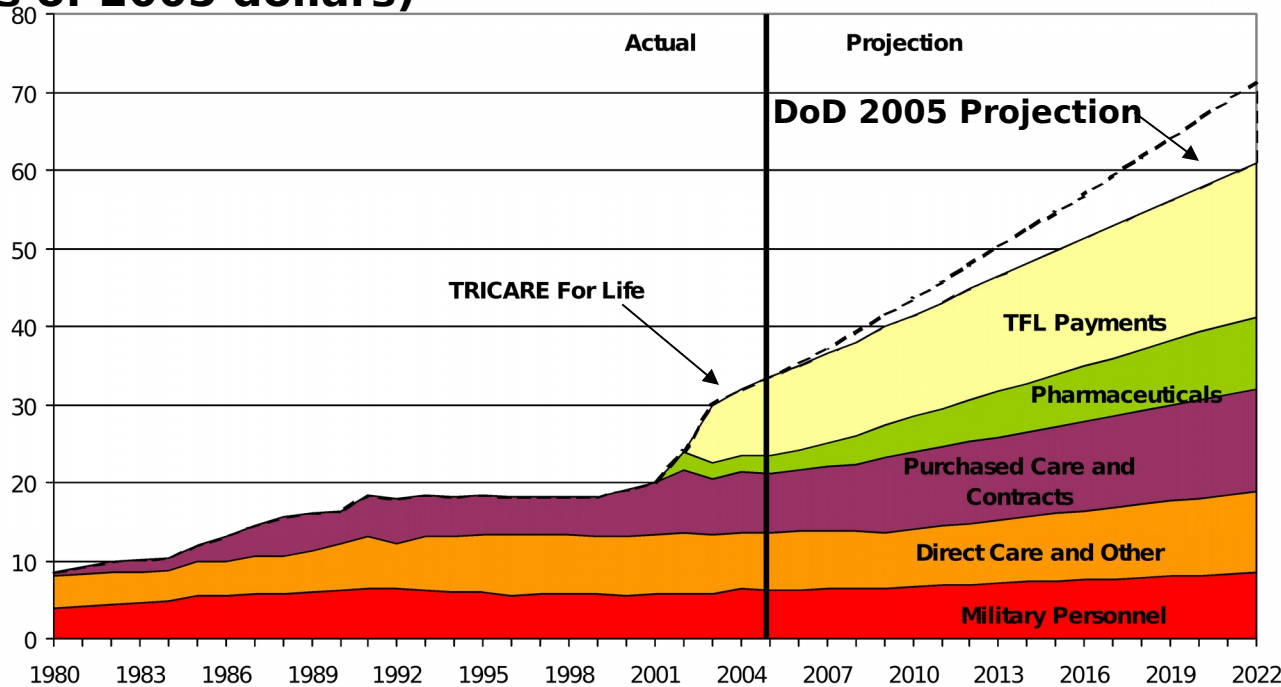
As of 9 JUN 06





Reality Check...a Blank Check?

(Billions of 2005 dollars)



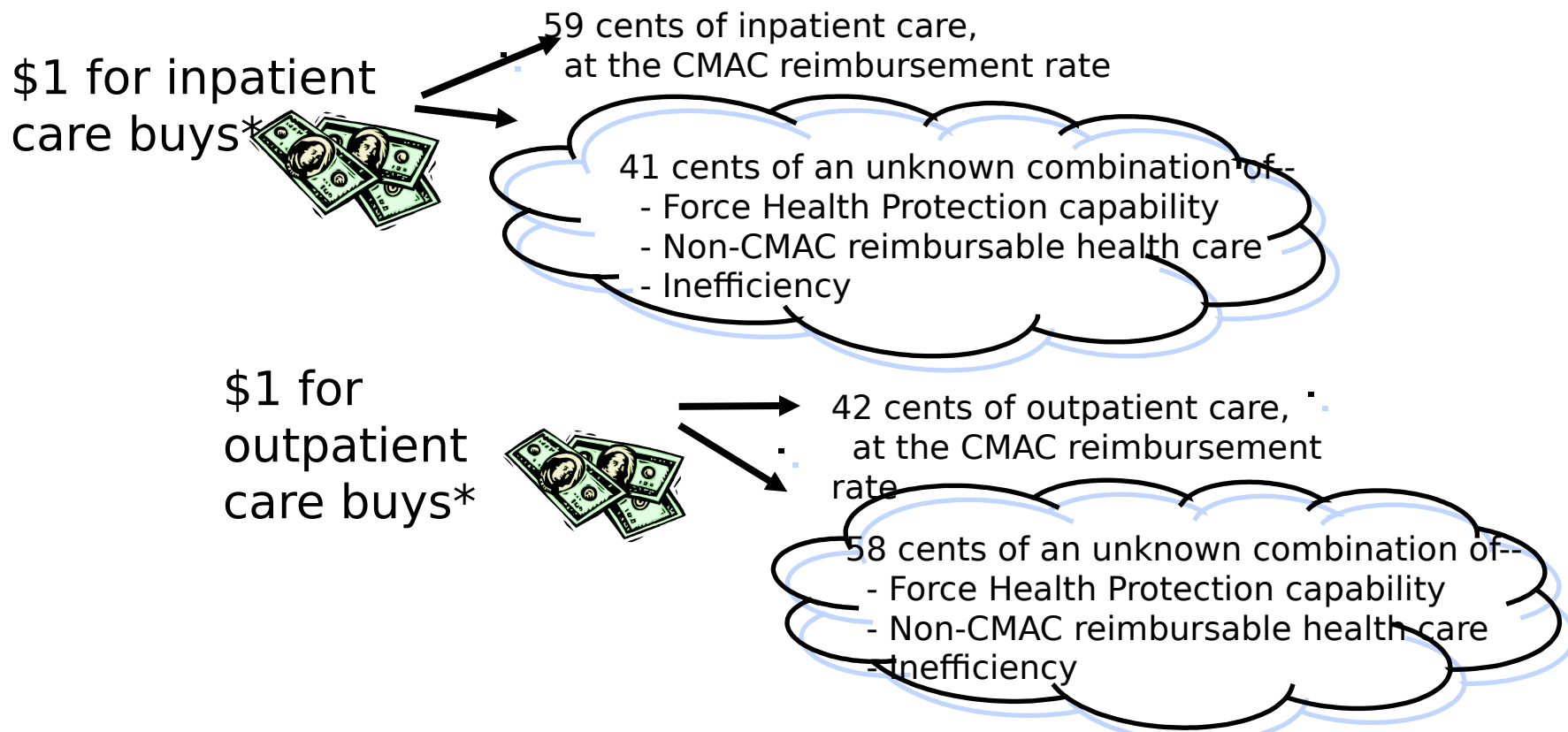
Source: Congressional Budget Office (2004); OSD (2005)

- Health budget rising rapidly: \$18B-2001, \$36B-2005, \$50B by 2010-2011 (est.)
- Due to new benefits (TRICARE For Life for over 65 population), very rich benefit with insufficient cost shares or indexes, Congressional expansions (TRICARE For Reserves), retirees under 65 opting for TRICARE vs. employer plans
- Aggressive effort to manage costs—New TRICARE private sector contracts (\$45B over 5 years), pharmacy formulary, pharmacy federal prices, closure/merger of military hospitals, improved business practices.
- Required—Benefit structure adjustments, to include indexed premiums/co-pays for long term control of cost growth; Health Savings Accounts must also be pursued.



The Price of the “Fog” – We appear to be inefficient, and we can not prove otherwise

- System cannot separate legitimate FHP efforts, non-reimbursed/able healthcare, and inefficiency



* Based on ASD(HA) Study, Perspectives on Efficiency in the Direct Care System



Critical to Developing a Strategy...

- Who are our stakeholders and what do they value?
- Who are our customers and what do they value?



Our MHS Stakeholders

Our stakeholders include:

- ❑ The Secretary of Defense, the Service Secretaries, the Joint Chiefs of Staff, Combatant Commanders, and Congress.

They desire:

- A medically ready and protected force
- The reduction of death, injuries and diseases during military operations
- Satisfied beneficiaries
- Healthy communities
- Effective management of DoD Health Care Costs



The MHS Serves two customer groups..... with different value propositions

■ **Combatant Commanders and Service Members** – Value Proposition = *Product Leadership*

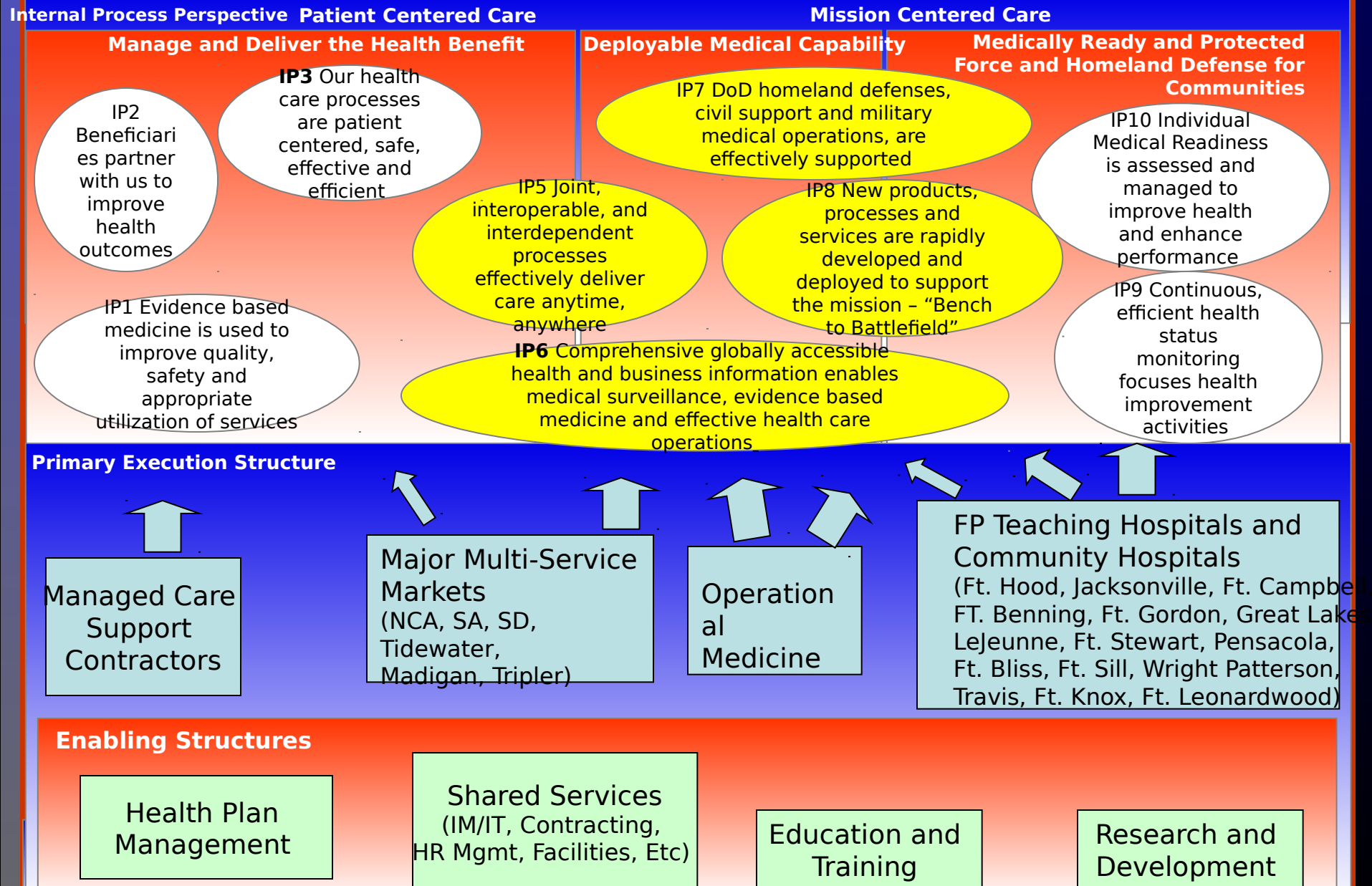
– In supporting Force Health Protection, our primary customers are the combatant commanders and the service members. We are their partners in creating a fit and protected force and they are confident we will provide the best possible medical care any time, anywhere.

■ **DoD Beneficiaries** –

Value Proposition = *Total Customer Solution*

– When we manage and deliver the TRICARE benefit, our primary customers are the DoD beneficiaries. They partner with us to improve their health because our system is convenient and because we provide them with evidence based medical advice and high quality

MHS Mission: To enhance DoD and our Nation's security by providing health support for the full range of military operations and sustaining the health of all those entrusted to our care.



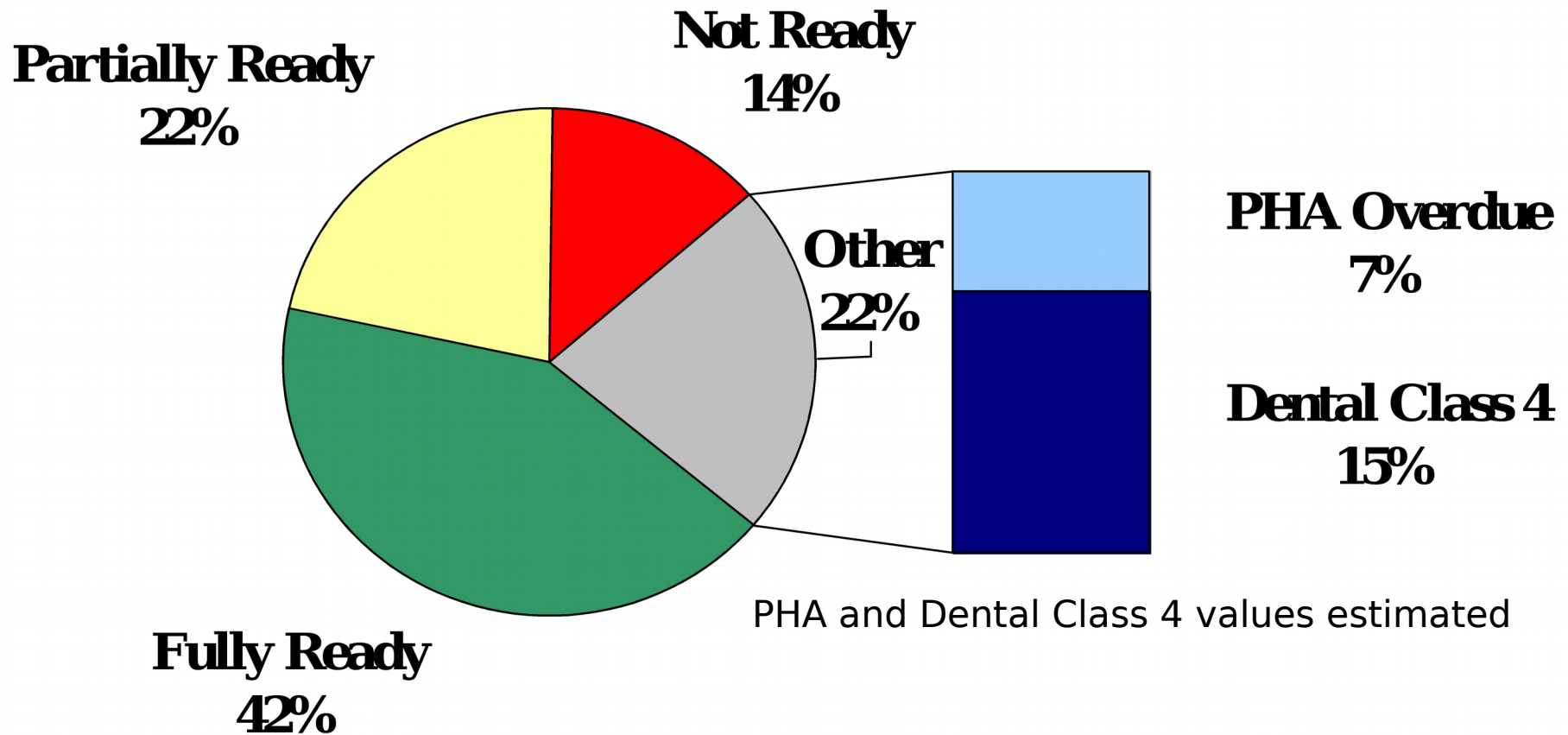


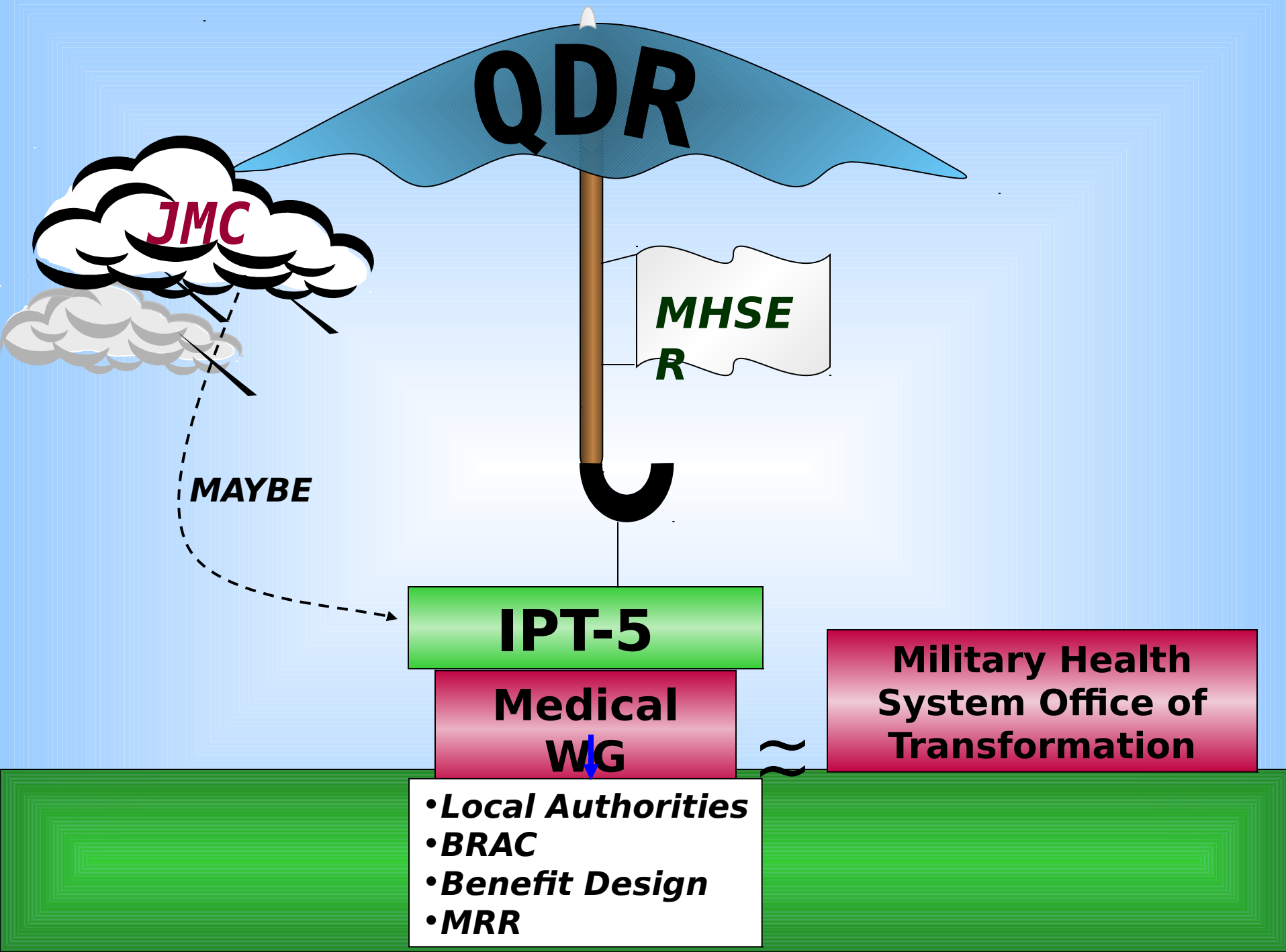
MHS High Level Measures – Translating Strategy to Operational Terms

- Forces are medically ready and protected
 - Individual Medical Readiness (IMR) Rate
 - Disease Non-Battle Injury Rate (Theater and CONUS)
- Death, injuries and diseases are reduced during military operations
 - Rate of Referrals from PDHRA
 - % of DNBI or Casualties moved to appropriate level of care
- Beneficiaries are satisfied with their care
 - Satisfaction with the health plan
 - Satisfaction with access
- The MHS creates healthy communities
 - Indexed measure of rate of tobacco use, alcohol use, obesity and activity level
- DoD Health Care Costs are managed,
 - Per Member per Month Medical Expense



DoD Total Force IMR Instrument Panel “Dial” Q2 FY2006 (Army, Navy, Air Force, USMC, USCG)







The MHS Transformation Mission

A continuing process to improve the performance of the MHS and its ability to effectively and efficiently —

- Provide a medically fit and protected military force, capable of performing across the full range of military operations
- Maintain a ready medical capability for supporting joint operations— during combat operations, stability operations, Homeland Defense, disaster relief and other 21st Century challenges
- Deliver high quality, cost efficient health care for the 9.2 million eligible TRICARE beneficiaries
- Sustain a superior health benefit that is affordable within DOD funding constraints

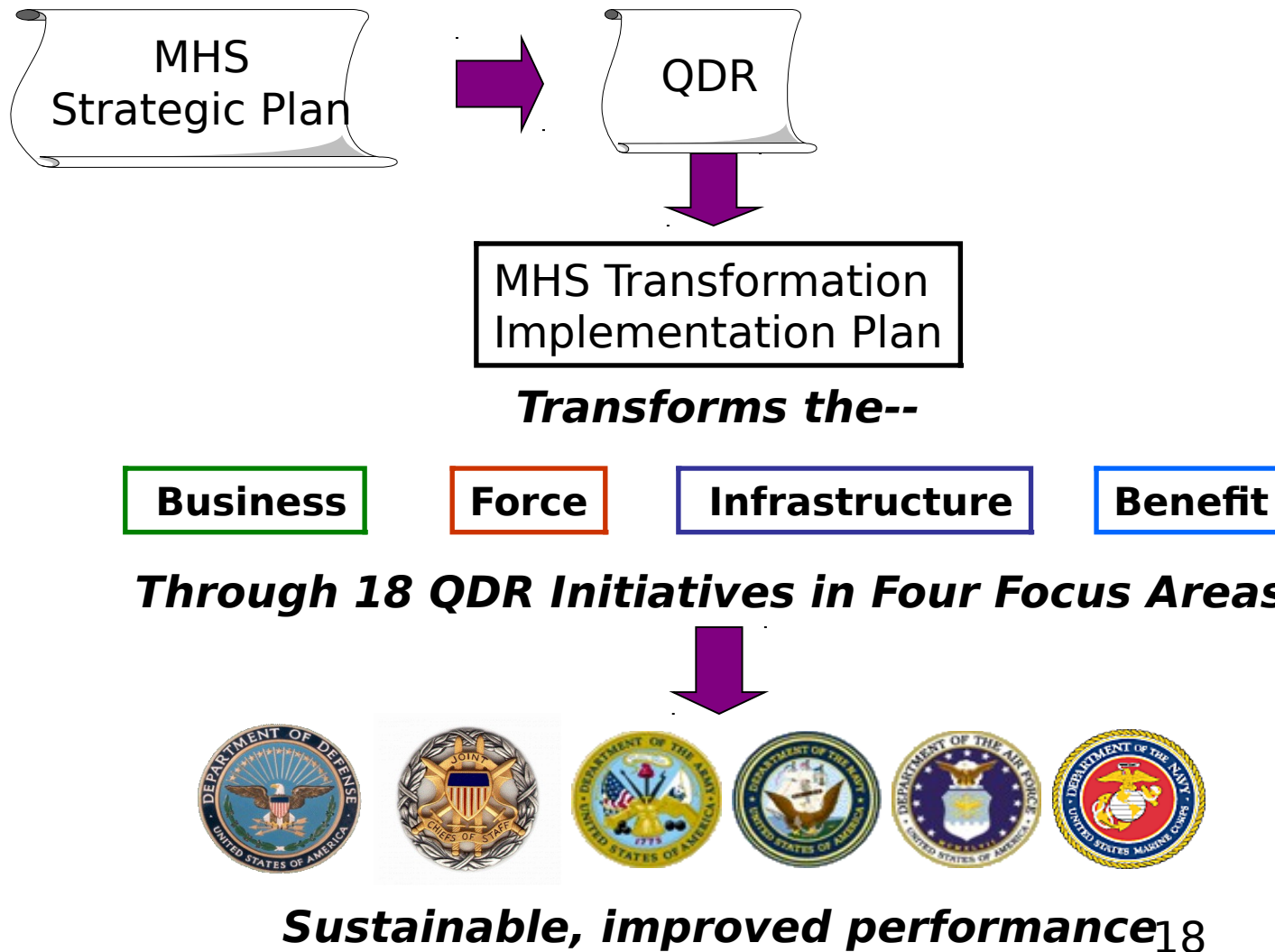
The foundation for the MHS Transformation is the Quadrennial Defense Review (QDR) and the MHS Strategic Plan

OFFICE OF TRANSFORMATION

- **Led by Deputy Surgeon General, Navy**
- **Guide the Entire MHS through our current dynamic transformation process**
- **Broad Charter to Roadmap implementation of BRAC and Medical QDR for the MHS**



From Plans to Performance





MHS Transformation Agenda

Provide the Joint Force with best-in-the world Operational Medicine/Force Health Protection (FHP), and high-quality, cost efficient health care for beneficiaries, four things are being done:

- **Transforming the Business:**

- Customer-focused and performance-based organization
- Effective processes to anticipate and respond to changes in health care

- **Transforming the Force:**

- Fully aligned with joint force, providing optimum, joint combat service support
- Rapidly responds to the needs of the changing national security environment

- **Transforming Infrastructure:**

- Reduce excess infrastructure and operate jointly in Multi-Service Markets

- **Transforming the Benefit (TRICARE):**

- Reinforce appropriate use of resources and demand for services



Transformation in the MHS Vigorous Pursuit Since 2002

- **Transforming the Business:**

- Strategic Planning - MHS Balanced Scorecard 2002
- Annual Business Plans across the entire MHS 2003
- Prospective Payment in Direct Health Care system - budget for value 2004
- Overhauled TRICARE Contracts - Consolidated regions, established multi-service markets 2004
- Delivered superior joint medical capability in Iraq and Afghanistan 2002 - Present
- Force Health Protection Advances
 - Pre and Post Deployment Health Assessments 2002
 - Joint Trauma Registry 2004
 - Medical Readiness Metrics 2006
- Global electronic health record - AHLTA 2005
- MHS Office of transformation with QDR Roadmap 2005

- **Transforming the Force:**

- Medical Readiness Review (MRR) 2004
- Military to Civilian Conversions 2005

- **Transforming Infrastructure:**

- Joint Cross Service work yielded fundamental re-shaping of MHS in BRAC 2005
 - Joint markets in the National Capitol and San Antonio
 - Joint education and research facilities

- **Transforming the Benefit:**

- Implemented benefits for Reserves, Medicare Eligible (over 65) 2003
- Uniform formulary, federal pricing 2005
- Sustain the Benefit campaign 2005



Highest Priority Issues

- Transform the **Force** and **Business**
 - Joint Medical Command
 - MRR / MIL to CIV Implementation
 - AHLTA/TMIP Implementation
 - Performance Based Culture
- Transform the **Infrastructure**
 - BRAC Implementation
- Transform the **Benefit**
 - Sustain the Benefit Campaign



Sustain the Benefit Campaign

- **Objective:**

- Pass legislation and implement rule changes for implementation beginning in 2007 to allow the Department to manage the benefit more effectively for the long term
- Save significant dollars (\$11+ B) for the Department over the POM

- **Original STB proposal met opposition but potential ways ahead identified**

- **Revised approach:**

- Retain cost share adjustment flexibility within the Department
- Obtain appropriate indexing rates for future fee increases
- Expedite GAO Study of MHS Costs
- Maintain TRICARE Reserve Select program as currently structured
- Obtain federal pricing for use in retail pharmacy
- Allow DoD to implement phased-in premium adjustments in FY2007



BRAC Implementation

- Objective:
 - \$3.6 B infrastructure re-engineering completed by 2011
 - Major restructuring in San Antonio and NCA
 - Creation of joint medical, education and research and development venues
 - Transition organization and culture to joint operations
- \$687 M shortfall despite efforts to reduce cost
- Integrated implementation consistent with goal of Medical Joint Cross Service Group and essential to achieve full benefit of joint facilities



AHLTA Implementation

- Objective:
 - Fully digitize global health care with AHLTA
 - Enable medical surveillance, evidence-based medicine, and effective health care operations
- Implementation is transforming the delivery of health care
- Pursuing health care and IT standards as part of a national effort
- Currently limited by differences in Service security and technology policies
- Sharing information in theater is the model



Medical Readiness Review

- Objective:
 - Ensure right number and skill mix for future military operations
 - Execute current MRR by converting MIL to CIV
 - Implement on-going process to continue to define the active duty operational requirement for MHS personnel
- Conversions create opportunity to optimize staff mix and capabilities
- Execution (rate and speed) of conversions cannot harm mission effectiveness
 - Ability to convert may depend on market conditions
- With expanding role of MHS in Homeland Defense and Civil Military operations, requirements may change

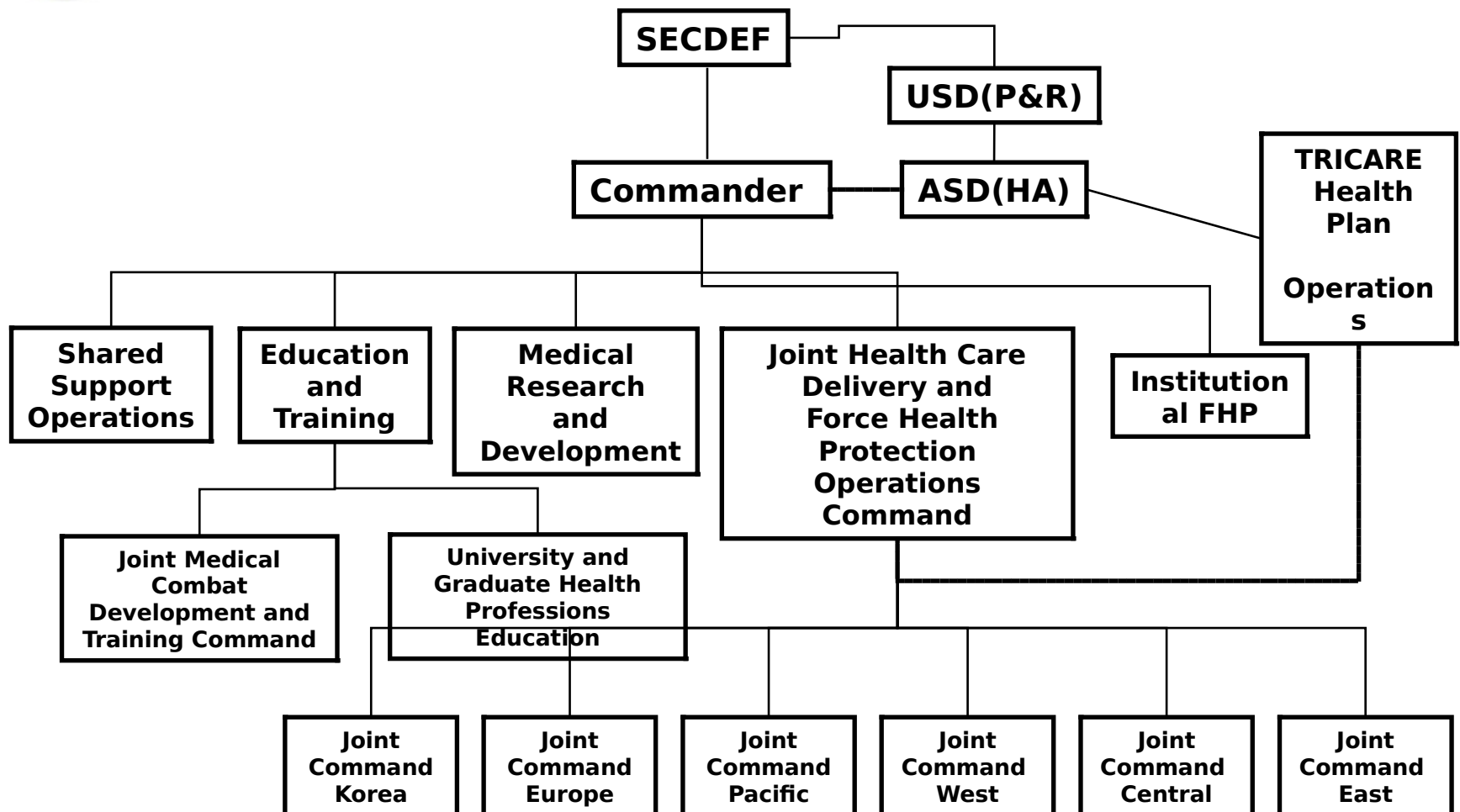


Joint Medical Command

- Objective:
 - Improved performance and joint support for both operational medicine and health care delivery
 - Alignment of authority and accountability
 - Appropriately embed J/UMC in an integrated enterprise model
- Courses of Action are being reviewed by OSD, Combatant Commands and Services
- Options being analyzed for Senior Leader discussion and decision



Example of an Integrated Health System Model



- Commander answering to SECDEF addresses legal concerns
- “Non command” authorities vested in ASD(HA) in a DoD Directive, as with ASD(SO/LIC) and USSOCOM
- “Health Plan” is ASD(HA) responsibility, Command focuses on service delivery



Integrated Health System (IHS)

- ❑ Corporate Business “Unit” Approach w/ Shared Services
- ❑ Readiness and beneficiary missions under a single authority
- ❑ Services retain responsibility for recruiting, military development, and their organic/embedded medical forces (e.g. medical personnel on a Navy carrier)
- ❑ All other medical support is “joint,” under the IHS
 - Services provide support through a Component Command structure
 - Non-organic medical forces assigned to IHS
 - IHS has health plan management and purchased care responsibility
- ❑ IHS has the training, education, RDT&E and shared services responsibility
- ❑ Current sourcing responsibilities remain unchanged

Old Paradigm		Transformational Thinking
<i>Why should we....</i>	To	<i>Why couldn't we...</i>
Two competing missions, health care delivery and force health protection	To	One mission, three interdependent themes
Meet requirements to staff facilities as echelons of care	To	Shape the force to achieve agile modular capabilities
Service specific infrastructure	To	Jointly staffed facilities
Budget and rules based	To	Performance based management
End year with no money left	To	End year with savings and meet performance goals
Independent Service Medical Departments	To	Interdependent Health Care Team
Beneficiary satisfaction surveys	To	Customer relationship management
By being unique and independent, ensure survival	To	Being interoperable and interdependent assures efficiency, customer value and survival.
Provider centered	To	Patient centered
Unmanageable costs, escalating benefit	To	Shape and sustain the benefit

Current State of DoD Health Affairs



Questions?